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**Governor's Bill No. 36 AN ACT CONCERNING THE GOVERNOR'S  
RECOMMENDATION TO IMPROVE ACCESS TO HEALTH CARE**

**PUBLIC HEALTH COMMITTEE**

Public Hearing February 28, 2014

**Testimony IN SUPPORT**

**Senator Gerratana, Representative Johnson, and Members of the Committee:**

I am a Family Psychiatric Nurse Practitioner and I have provided psychotherapeutic and psychopharmacologic services for persons with mental illness in Connecticut since completing my nurse practitioner training at Yale University in 2000. I have a private practice in New Haven where I treat approximately 500 patients and I have a collaborating physician. She is one of the many colleagues with whom I collaborate to manage my patients as they seek wellness and symptom relief. We have engaged in a fruitful relationship for the last 11 years. She is the collaborating MD for most of the New Haven County APRNs. If she were to leave her CT-based practice, many thousands of mentally ill patients may be without care if we are unsuccessful in striking a mutually acceptable collaborative agreement with another psychiatrist. I have had disruptive and ill-informed interactions with psychiatrists in the past as I have attempted to find a collaborator.

Additionally, I am a member of the medical staff that serves two not-for-profit clinics offering psychiatric services, primarily, to our most indigent of mentally ill people. I also provide the psychiatric assessment and medication management for New Haven based mentally ill prisoners transitioning from their DOC sentences back to their communities. In both settings, I am part of a multidisciplinary team that offers a range of psychiatric and substance abuse services aimed at reducing relapse, maintaining a productive life with mental illness, and reducing recidivism.

Among all settings, we manage approximately 2,000 patients, most with serious and persistent mental illness. My collaborating MD in these facilities is close to retirement. He brings years of wisdom, a healthy respect for my independent practice, and a generous relationship with these financially challenged clinics. He has submitted a statement in support of Governor's Bill No. 36 that I have attached. When he retires over the next few years, the 2,000 patients we serve may experience a break in those services given the current legislative mandate of collaboration.

Collaboration is one of the many clinical and ethical mandates that all practitioners of medicine are encouraged to employ in our quest for optimal patient care. It happens naturally as we consult with each other daily in providing care and relationships are formed among providers. We assume respect for colleagues in various specialty practice settings and ultimately refer patients back and forth as their medical needs change.

The process of mandating collaboration with regulatory statute distorts its true spirit and provides a forum for great misuse of power, misassumption of patient responsibility, and indentures APRNs to physicians for whom previously collegial relationships are forced to become parental. As outlined in the *Medical Economics* article attached, it does offer great financial reward for physicians. However, if we are unable to find a reasonable and knowledgeable collaborating MD willing to sign this document, our practices close and patients are not able to access care. Nothing changes in the day to day operations of my psychotherapy and medication management practice whether I have a written agreement with an MD or not, but the act of needing to have one constructs a barrier that can bring patient access to mental health care to an immediate and unnecessary halt.

This current public health policy overtly restricts the establishment and maintenance of mental health services. At a time when this access to care needs to be most available to our most vulnerable population, I urge your support of this legislation to help reverse a proven bad policy.

I want to also thank the Department of Public Health for establishing the forum for our most recent Scope of Practice Review. It was an honor to serve on the committee and I am pleased at the evidenced-based outcomes that provide support for what Governor's Bill No. 36 is attempting to achieve.

Respectfully submitted,

Danielle Morgan, MSN, ANP, CNS, Family PMHNP, APRN-BC  
Family Psychiatric Nurse Practitioner

## How hiring a physician assistant or nurse practitioner could ease a physician's work load, increase take-home pay, and more

H. Christopher Zaenger, CHBC

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If you are having trouble finding physicians to join your practice, dismayed by their demands or expectations at interviews, or concerned about their high cost or need to be a partner, hiring a physician assistant (PA) or nurse practitioner (NP) may be your answer.

Hiring midlevels can ease the physician's practice pressures, increase take home income, and increase patient satisfaction. A primary care entrepreneur can earn as much as a surgeon and more.

### A real-life example

Enter Alfonso Alvarez (the names have been changed to protect confidentiality), a family physician and the sole owner of La Vida Health Center, S.C., a family medicine practice in Waukegan, Illinois.

When I began consulting Alvarez in 2010 he was already doing well. Statistics for 2009 from the National Association of Healthcare Business Consultants indicated that family practitioners were taking home \$184,382 (33%) on \$559,584 in receipts. The average practice had two physicians and about one-third of the practices used a midlevel provider. Alvarez would generate \$809,000 and retain 35% of it. He was earning \$100,000 more than the average using one full-time-equivalent PA.

So as an observer, I said: "If the meal is good why not go for seconds?"

Alvarez hired a second PA, the limit in Illinois at the time. Then a providential change in state law allowing the physician to supervise up to five PAs was passed. Cycle time to fully busy was less than 6 months. Then Alvarez decided to hire a third PA. His take home income in 2010 increased by 29%.

In 2012, I devised a productivity incentive program that resulted in a huge boost in the productivity of the midlevel support staff. His PAs will earn more than \$120,000 each this year while each will produce over \$400,000 in receipts. He just doubled his office space and expanded office hours. His operating expenses climbed by 34% since 2010, and he added debt due to a large expansion of his office footprint. His take home income in 2013 will be significantly more than twice what he earned in 2010.

Now with the passage of the Affordable Care Act (ACA) and the creation of the Patient Centered Medical Home, (PCMH) the practice is looking to the "community health" model. Alvarez is adding an NP to help with care coordination and management of the statistical reporting requirements and implementation of the PCMH tools within his electronic health record (EHR).

Alvarez is one of many physicians implementing this model with success. The bottom line is that midlevel providers, if productive, do not cost a practice anything and can actually increase revenue.

### **Should you hire a midlevel?**

Remember, the new competitor in healthcare delivery may not be your local hospital. It may be the CVS or Walgreens on the corner or an entrepreneur building a high-access clinic down the street in states that allow them.

Because of these competitive pressures, midlevels may be the best way to expand your practice, increase the amount of net income per square foot of space, and provide you with a lifestyle that creates more freedom of choice.

If you answer 'yes' to these questions, you may be the perfect candidate to hire a mid-level:

- Do you know your state law and limits?
- Is your practice fully busy?
- Do you have a full waiting room at times during the week?
- Do you have a day of the week that is "crazy?"
- Can you double book and keep up?
- (Are patient waiting times an issue?)
- Are you booking new patients more than 3 weeks out?
- Are you offering 30 hours of office clinic time per provider?
- Are you having trouble recruiting another physician?
- Can you spare an exam room
- or two and/or expand hours?
- Can you cover the first 4-5 months
- of salary for a midlevel?
- Can you filter for the hard worker
- in your interviews?

The American Academy of Physician Assistants credential verification service, offered in conjunction with the American Medical Association, is a great tool for verifying candidate credentials. Two certifications employers should look for are the Physician Assistant National Certifying Exam (PANCE) for recent graduates and the Physician Assistant National Recertifying Exam for PAs who have been practicing for more than 5 years.



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